UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION

DEBORAH DeMARIS, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C03-3016-MWB **REPORT AND RECOMMENDATION**

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I. INTRODUCTION

The plaintiff Deborah DeMaris ("DeMaris") appeals a decision by an administrative law judge ("ALJ") denying her Title II disability insurance ("DI") benefits. DeMaris argues the ALJ erred in (1) finding her subjective pain complaints were not credible; (2) rejecting the opinion of her treating psychologist; and (3) finding she has the residual functional capacity to perform substantial gainful activity. DeMaris argues that because of these errors, the Record does not contain substantial evidence to support the ALJ's decision. (*See* Doc. No. 7)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On March 9, 2001, DeMaris filed an application for DI benefits, alleging a disability onset date of May 31, 1996. (R. 78-80) The application was denied initially on June 20, 2001 (R. 64, 66-69), and on reconsideration on September 19, 2001 (R. 65, 71-74). On October 1, 2001, DeMaris requested a hearing (R. 75), and a hearing was held before ALJ Andrew Palestini on April 4, 2002. (R. 28-63) DeMaris was represented at the hearing by attorney Evelyn Ocheltree. DeMaris and her husband, Louis DeMaris, testified at the hearing, as did Vocational Expert ("VE") Roger Marquardt.

On September 19, 2002, the ALJ ruled DeMaris was not entitled to benefits. (R. 10-25) On November 15, 2002, DeMaris requested review of the ALJ's decision. (R. 8) The Appeals Council of the Social Security Administration considered additional evidence submitted by DeMaris subsequent to the ALJ hearing (R. 4, 234-56), and on December 21, 2002, the Appeals Council denied DeMaris's request for review (R. 5-7), making the ALJ's decision the final decision of the Commissioner.

DeMaris filed a timely Complaint in this court on March 28, 2003, seeking judicial review of the ALJ's ruling. (Doc. No. 3) In accordance with Administrative Order #1447, dated September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge, pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of DeMaris's claim. DeMaris filed a brief supporting her claim on June 19, 2003. (Doc. No. 7) The Commissioner filed a responsive brief on August 12, 2003. (Doc. No. 10). DeMaris filed a reply brief on August 25, 2003. (Doc. No. 11) The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of DeMaris's claim for benefits.

B. Factual Background

1. Introductory facts and DeMaris's daily activities

a. DeMaris's testimony

At the time of the hearing, DeMaris was 46 years old. She lived in Kensett, Iowa, with her husband Louis, to whom she had been married for 27 years. DeMaris had one daughter, who was not living with her parents. (R. 31, 32) DeMaris was 5'5" tall and weighed around 260 pounds, which she stated was 20 to 25 pounds more than her normal weight. According to DeMaris, her weight gain was a side effect of some of her medications. (R. 32)

DeMaris took a one-year cosmetology course after high school, and she took some correspondence courses to learn home health care. (R. 31-32, 34) She stated she had worked as a nursing assistant, which required "a lot of maneuvering as far as transferring patients and helping them to feel comfortable." (R. 33) She had to lift and move patients regularly. She prepared meals, administered medications, and did housekeeping duties as needed. (R. 33-34)

DeMaris stated her last job ended in the late summer or early fall of 1996, when a couple for whom she had been caring died and her services no longer were required. (R. 35) About eight months before the job ended, DeMaris explained she "had literally sat up in bed to go to work and [she] had a pain shoot through [her] left side, the total left side[.]" (R. 35-36) She told her employer what had happened, and that she had difficulty walking and performing some tasks, and her employer was understanding and accommodated her limitations. (R. 36) When the job ended, DeMaris did not seek another job because of her pain and discomfort. She stated she wanted to wait to look for work until she could control her pain. (*Id.*) By the time of the ALJ hearing, she still did not feel able to return to work as a home health aide, explaining:

> [I]n nursing, it's quite important, you know, when you say you'll be there and this type of thing especially with hospice or Amacare where the families need you there. And the pain is so unpredictable that I just can't – I just don't feel that I could commit right now to any family or any situation until better control of the pain.

(R. 37) She noted, "I know I have to keep going, but to commit myself to another person or another situation as far as help, physical help I just – I don't feel that I'm able to do that right now." (R. 47)

DeMaris stated doctors have suggested her pain is caused by fibromyalgia or neuropathy. She is diabetic and suffers from high blood pressure. She stated the pain leaves her feeling hopeless and "not knowing what to do." (R. 37) Sometimes her medications help, but not for an extended period of time. (*Id.*) DeMaris indicated she suffers from depression. She used to suffer from panic attacks or anxiety, but those are controlled by Prozac, which she has been taking for quite awhile. For the pain, she takes Darvocet and Vioxx, and she takes Amitriptyline at night. (R. 38-39) She also sometimes takes Tylenol Arthritis, regular Tylenol, Advil, Excedrin, Aleve, and aspirin, experimenting to

see what will give her the most relief. (R. 40) About once a week, she will take more than the prescribed or recommended dosage of her medications because of extreme pain. (R. 43, 46)

DeMaris explained her pain moves to different areas of her body and is not confined to a single place. (R. 44) She reported that for the three days preceding the hearing, she had experienced pain on her left side, down her leg, and a sharp pain in her left arm. The sharp pain then "transferred over" to her right arm. (R. 43) The sharp pain will last varying amounts of time, from an hour or so to several hours. (R. 43-44) She described the pain as feeling "like a jolt of electricity in [her] joints" that sometimes feels like "twisting." (R. 44) DeMaris stated she will get relief with medication between 10% and 25% of the time, but she had not had a pain-free day and night in the preceding five years. (*Id.*) She stated the pain is unpredictable, and it affects her ability to walk and stand. For example, she stated:

> When I try to walk, some days I have a twisting that goes in my leg all the way up. And then like say from the car to the doctor's office, walking that distance and I would say 90% of the time I'm in pain just in that short of a distance.

(R. 45)

She stated she sometimes can stand for five to ten minutes before the pain requires her to sit down or lie down. (R. 45) She can sit for up to thirty minutes at a time before she has to move due to pain, and then she will get up and move around, lie down, use a hot pack or ice pack, or soak in the tub. (R. 45-46) She sometimes goes with her husband to do the grocery shopping, but stated it is difficult for her, and even if she is not having a lot of pain, the automobile ride to the store may cause the pain to increase to the point that she does not go into the store. (R. 54)

DeMaris stated she limits her activity. She can work on a household chore for ten to fifteen minutes before she has to rest. (R. 46-47) She can do the dishes, dust, and cook meals, and she can vacuum one room but then has to sit down. (R. 51) She takes hot baths every day, sometimes more than once in a day. She likes to read, but sometimes has trouble concentrating. (R. 46, 52) While she is sitting, she will try to keep moving, raising her arms or legs, which she stated is supposed to help her fibromyalgia. (R. 46-47) She lays down several times a day, and when laying down is painful, she will "sit back up or . . . get in the tub." (R. 52) She likes to listen to music, and she watches TV. (*Id.*) Occasionally, perhaps once or twice a month, she will just stay in bed all day. (R. 54)

DeMaris stated she does not go out on a regular basis. She keeps in contact with friends by telephone, and she does not belong to any clubs or social organizations. She attends church, but is unable to go every week because sometimes sitting will give her problems, while at other times she has problems riding in the car to get to church. (R. 51-52, 54) She has a license and is able to drive, but her husband usually is with her. (R. 52, 56) She spends time with her grandchildren, but stated someone else has to be present because she cannot lift the children. (R. 55) She does not try to lift anything heavier than the dishes, stating she has pain even when she is not lifting anything. If she tries to lift things, the pain increases, and she is afraid it will become uncontrollable. (R. 55-56)

She stated she can sleep a couple of hours at a time before she awakens. Sometimes she can go right back to sleep, and other times she may be awake for 15 minutes. Then she can sleep for another two hours. She awakens frequently either due to pain, or because her diabetes causes her to have to go to the restroom. (R. 48-49)

DeMaris described periodic difficulty with her hands, stating she has dropped dishes. She explained, "I had the sensation or the feeling that I was holding onto it and yet it fell out of my hand." (R. 49) She stated she will have this experience every few

weeks. She has talked to her doctors about the problem, and she believes the problem is related to both her diabetes and her fibromyalgia. (R. 50) She stated she can reach above her head "once or twice and then pain does come." (R. 53) She opined she could use her feet to push things, but not for an extended period of time. (R. 53-54)

DeMaris reported that she takes three different medications for high blood pressure and two medications for diabetes. (R. 39) She stated the doctor wanted to add a third medication for diabetes, but she could not afford to fill the prescription. (R. 39-40) She has to have blood work done every two to three months to monitor possible adverse effects from her diabetes medications. (R. 50) She stated she has experienced some vision problems, such as blurriness or seeing stars or dots in her vision. The blurriness is almost daily, but it is not constant. Her family doctor has examined her eyes, but she could not afford to see an ophthalmologist. (R. 50-51)

DeMaris stated her treating physician had changed recently. She had been seeing Dr. Brinkman at the Mason City Clinic, but he had retired. She stated she goes to the clinic on average every two months, to monitor her blood pressure and diabetes, and to discuss her pain. (R. 40) She was referred to Dr. Marion Jacobs "to get a clearer diagnosis of how to cope with [the] pain and get a clearer vision of what it is and how to handle it." (R. 41) She saw Dr. Jacobs in February or March 2002. DeMaris stated doctors have recommended she undergo "extensive testing," but she has declined because of the cost. She has no medical insurance and her husband is self-employed. She stated she receives free samples of some medications every month, but others have to be obtained through the pharmacy, and she sometimes goes without her medications because she cannot afford them. (R. 41-42)

DeMaris stated she had seen a doctor for depression and anxiety in the past, but those conditions were now well controlled by Prozac. (R. 42-43) She stated her diabetes had "not been under control for years," despite following her doctors' orders. (R. 43)

She tried to see a chiropractor once but, according to DeMaris, the chiropractor would not work on her because of the seriousness of her pain, her diabetes, and bone spurs in her back. (R. 48)

b. Louis DeMaris's testimony

DeMaris's husband, Louis DeMaris ("Louis"), testified that he sees his wife during the day frequently because he is self-employed and his business is located at their residence. He stated he observes her being in pain "[a]ll the time." (R. 57) She tells him that she is in pain, or he will see her in bed, sometimes as many as three or four times a day. She frequently asks him to massage the affected areas. He had seen his wife in tears or upset due to pain on two or three occasions in the year preceding the hearing. (R. 57)

Louis stated he helps with household chores "[o]nce in awhile," once or twice a week. (R. 58) He stated DeMaris can drive, but riding in the car causes her to have pain. (*Id.*)

Louis stated he is in the salvage business and cannot afford to buy health insurance. (R. 59)

2. DeMaris's medical history

The earliest medical evidence in the Record is when DeMaris saw Dr. Brinkman at the Mason City Clinic in January 1995, to recheck her hypertension and diabetes. Her blood sugar was high, and the doctor increased her Micronase. She was advised to return in three months for another follow-up exam. (R. 148) DeMaris was seen later in January

for an upper respiratory infection. She next saw Dr. Brinkman in May 1995, when he noted she had "not been taking her medication regularly because of the expense," and the doctor was attempting to get her on cheaper medications. DeMaris also had not adjusted her Micronase as Dr. Brinkman had ordered in January. (R. 147) DeMaris asked to switch her blood pressure medication from Vasotec to Monopril. However, her blood pressure rose after the switch, so she was put back on Vasotec. (R. 146)

DeMaris went to the clinic on June 19, 1995, complaining of intermittent left leg pain. The doctor noted possible causes were "a subacute herniated disk," "arthritis of the knees," and, due to DeMaris's "noted size" (DeMaris weighed 268 pounds at the time), "the possibility of a subacute deep vein thrombosis," although she did not have any edema. (*Id.*) He recommended she undergo an MRI of the lumbar spine, but DeMaris refused because she did not have insurance. She was advised to rest as much as possible, refrain from exercising, and use a heating pad, but the doctor specifically noted he was not restricting her from work. (*Id.*) DeMaris was supposed to return for a recheck in one week, but there is no indication she did so.

DeMaris saw Dr. Brinkman on July 24, 1995, complaining of "anxiety depression with panic attacks." (R. 145) He noted she had "a long-standing history of depression," and had been hospitalized five years earlier. The doctor placed her on Paxil, which provided some relief, and DeMaris was to return for follow-up in two weeks. She was referred to "Mental Health." Her weight was down slightly, to 261½ pounds. (*Id.*)

Dr. Brinkman next saw DeMaris nineteen months later, on February 27, 1997, when he reevaluated her hypertension. Her Vasotec was increased, and the doctor planned to switch her to Accupril when the Vasotec ran out. He noted that because she did not have insurance, "samples were given to her and she does not want any tests done."

(R. 143) DeMaris was advised to return for follow-up in three weeks, but there is no indication she complied.

DeMaris next saw Dr. Brinkman on October 1, 1997, for recheck of her hypertension. He added Hydrochlorothiazide to her medications, and told her to return in two weeks for a blood pressure check and in three months for a follow-up examination. The doctor noted, "[T]he patient has no insurance and does not wish laboratory studies done, although I told her it was in her best interest to do so." (R. 144)

DeMaris saw Dr. Brinkman on December 4, 1997, for mild gastroenteritis; and on May 4, 1998, for an inflamed cyst under her right jaw. (R. 140-42) On June 1, 1998, DeMaris called the doctor's office to report she had run out of Hydrochlorothiazide, and she wanted to know if she should continue to take the medication. Dr. Brinkman said she should, and a prescription including one year of refills was called into the pharmacy. (R. 140) DeMaris called the office again on July 15, 1998, and reported her blood pressure was 160/98. She asked if she should increase her Hydrochlorothiazide. Dr. Brinkman said she should not, and told her to come into the office in one week to check her blood pressure and see if any adjustments should be made to her medications. (R. 139) There is no indication DeMaris complied.

DeMaris stopped by the doctor's office on November 27, 1998, to request samples of Plendil and Paxil. She received the Plendil samples, but the nurse noted she had not seen the doctor for several months, and she advised DeMaris to make an appointment. (R. 138) According to the nurse, DeMaris "was skeptical," and the nurse stated she would ask the doctor for authorization to give DeMaris more samples. She gave DeMaris enough Paxil for one week. (*Id.*)

DeMaris saw Dr. Brinkman on December 29, 1998, for follow-up of her hypertension. She reported she was feeling well. Her blood pressure was 154/84. No

changes were made to her medications, and DeMaris was advised to return for follow-up in four months. (R. 137) There is no indication in the Record that she did so.

DeMaris was seen for a routine blood pressure check on November 15, 1999, when her blood pressure was 148/88; and on February 8, 2000, when her blood pressure was 142/88. (R. 210-11) When she returned for a blood pressure check on April 3, 2000, she was out of Plendil samples and the doctor did not have samples to give her. She reported that she had samples of Norvasc at home, and Dr. Brinkman previously had told her she could take Norvasc in place of Plendil, so she had done so; however, she began not feeling well, complaining of fatigue, elevated blood sugar, and a tightness in her chest. She wanted to continue taking the Norvasc because she could not afford to fill a Plendil prescription. The doctor's assistant talked to DeMaris about getting into an indigent program, and referred her to "Gloria Hudson at Elderbridge" to see if there was a program DeMaris could get into. DeMaris was advised to return in a couple of days if she did not begin feeling better. (R. 209)

DeMaris called back on April 7, 2000, to report her blood sugars were still elevated, averaging around 300. The doctor's assistant noted DeMaris had been off all diabetic medications "for about one year due to cost of medications and office visits," and she tried to convince DeMaris to make an appointment with Dr. Brinkman. DeMaris stated she was "due to see Dr. Brinkman in another month." The doctor's assistant gave DeMaris samples of Amaryl, and she was told to call back in a week to report on her blood sugar. (R. 208) There is no notation to indicate she complied.

On May 31, 2000, DeMaris saw Dr. Brinkman for a physical examination. She reported her blood sugars were running in the 140 range. Dr. Brinkman noted DeMaris had a history of Type II diabetes, and a six-year history of hypertension, and she was taking Plendil, Accupril, and Hydrochlorothiazide. He also noted she had a history of

"anxiety and depression," for which she was taking 20 mg. of Prozac twice a day. At the examination, DeMaris's blood pressure was 140/90, and she weighed 247 pounds. Dr. Brinkman recommended she lose weight, and he ordered lab studies. He advised DeMaris to monitor her blood sugar more frequently, and return to see him in three months. (R. 204-05) The results from the lab studies showed DeMaris's glycohemoglobin to be high at 11.0, based on an acceptable range of 4.3-6.0. Her glucose was high at 250, based on a range of 70-110. (R. 206)

Also on May 31, 2000, DeMaris underwent a bilateral mammogram, as a baseline. The study indicated some bilateral nodular densities which were noted to be "[p]robably benign." (R. 207) It was recommended she have a follow-up study in six months. (*Id.*) At a gynecological appointment on August 14, 2000, DeMaris was diagnosed with fibrocystic disease of the breasts. (R. 199) The follow-up study on November 20, 2000, was negative, and DeMaris was told to have regular yearly screening. (R. 197)

On June 13, 2000, DeMaris was seen in the emergency room with complaints of vomiting for several hours. She reported a burning sensation in her stomach and chest, and reported she could not stop vomiting. She was diagnosed with suspected gastritis, and her blood pressure was elevated. She was given Compazine and IV Pepcid. She was discharged with a prescription for Zantac, and instructions to "encourage fluids" and follow-up with Dr. Brinkman. (R. 149-50)

DeMaris returned to the emergency room on June 14, 2000, reporting she was continuing "to have episodic regurgitation" and she could not swallow water. She could not recall getting food caught in her esophagus, but reported problems with transient food impactions in the past. She was treated with Pepcid IV, Compazine, Ativan, and Glucagon, none of which provided any relief. The E.R. physician obtained a consultation from Satish K. Sondhi, M.D., and he performed an EGD and removed a large piece of

meat. He noted a small hiatal hernia and a mild Schatzki's ring at the gastroesophageal junction. Dr. Sondhi advised DeMaris to chew her food thoroughly prior to swallowing. (R. 151-54)

On June 23, 2000, DeMaris called to request more samples of Accupril. The doctor did not have samples available, and switched her to Prinivil. (R. 203)

On July 13, 2000, DeMaris called Dr. Brinkman with complaints of back and leg pain. She reported she had had the condition "for about four years" and it "continue[d] to bother her." (R. 201) The doctor advised her to try Tylenol Arthritis, and she was advised to keep her appointment scheduled for July 31, 2000. (*Id.*) DeMaris made the July 31 appointment. Her weight was down to 201 pounds, and the doctor noted her foot care was good. Her medications were not changed. She was advised to return in two months for additional lab studies. (R. 200) DeMaris appeared for a blood pressure check on August 16, 2000, when her blood pressure was 126/82. (R. 198)

DeMaris was examined by a physician's assistant ("PA") at Dr. Brinkman's office on March 2, 2001, when she reported "multiple complaints." (R. 192) She complained of "a four and one-half year history of back, left shoulder, and left leg pain"; pain in her right ear radiating down into her right neck; and a rash on her neck. (*Id.*) DeMaris gave the following history with regard to her pain complaints:

> When questioning her about her pain she tells me that it actually migrates. It can be in the muscles in her back. It can travel either in the front of the left shin or the left thigh. Sometimes even go over to the right. It can bother her right arm and give her headaches in the left side. She does not have any neurologic symptoms. She has been denied chiropractor

> care for an uncertain reason. She has no weakness or numbness. She has not recently fallen. She has used Tylenol Arthritis and every over-the-counter medication available. Nothing works.

(*Id.*)

The PA noted DeMaris was "an alert well kempt although depressed appearing woman in no acute distress," and she was obese at 247.7 pounds. (*Id.*) The PA diagnosed DeMaris with musculoskeletal back pain, which DeMaris reported was relieved somewhat by massage. The PA doubted DeMaris had a disk problem or pinched nerve, and noted DeMaris's hypertension was "[n]ot well controlled today" at 152/96, "with a goal of 130/75 in this diabetic woman." (R. 193) The PA also noted DeMaris's diabetes was "probably poorly controlled," and had not been tested for seven months, and the PA found folliculitis on DeMaris's anterior neck. (*Id.*)

Dr. Brinkman discussed depression and fibromyalgia with DeMaris. The doctor indicated he did not know what was causing her pain, and suggested she "try to get moderate exercise and even join the YMCA and use [their] warm therapy pool for exercise." (*Id.*) He prescribed Vioxx (giving her samples), Imipramine, and Cephalexin for the folliculitis, and he ordered lab tests. He directed DeMaris to return in three to four weeks for follow-up. He did not see any indication that an MRI was warranted. (*Id.*)

A nurse called DeMaris on March 23, 2001, to remind her to schedule a follow-up appointment. DeMaris stated she would "set up an appointment in the near future" (R. 191), but it appears she did not see the doctor again until June 25, 2001. (R. 188; *see* discussion, *infra*)

On May 15, 2001, Steven B. Mayhew, Ph.D. performed a psychological evaluation of DeMaris at the request of Disability Determination Services. (R. 156-57) DeMaris reported a history of depression secondary to fibromyalgia, which she stated was

confirmed by diagnosis in February 2001. (R. 156) She stated she had suffered from depression and panic attacks for several years, but her panic attacks were controlled somewhat by medication. She also reported a history of diabetes for ten to twelve years, hypertension for fifteen years, and bone spurs in both feet. (*Id.*) Upon examination, Dr. Mayhew found DeMaris was adequately groomed, and she was alert and oriented. Her affect was appropriate, and she had logical, coherent, and goal-directed thought processes. The doctor noted her "[m]ood appeared to be that of anxiety with mild depression." (*Id.*)

DeMaris evidenced difficulty with simple, numerical calculations. She had poor five-minute recall, and a limited knowledge both of current events and of general information. She gave adequate responses to questions of social judgment and common sense reasoning. DeMaris gave the following description of her normal daily routine:

> [DeMaris] states that she is typically up between 5 and 7 a.m. She takes ten different medications and tries not to over exert herself physically. Doing so causes increased pain. She avoids lifting and stooping. She reports pain as mainly in her back but also spreads to her arms and legs. She states that her pain can vary significantly from one day to the next as well as one hour to the next. The pain tends to also shift from one body area to another for unexplained reasons. She is able to read and write and prepare meals. She is able to do laundry some days though problems with lifting would interfere with this. Grocery shopping is adequate though she would appear to become easily fatigued and easily tired if having to walk long distances or for a prolonged period of time to be standing. She co-manages the finances with her spouse. She does have a driver's license and drive.

(R. 156-57)

Dr. Mayhew diagnosed DeMaris with major depression, recurrent; history of panic attacks; suggestion of dependent personality features; and a GAF of 48 (R. 157), which

would indicate "serious symptoms . . . or any serious impairment in social, occupational, or school functioning[.]" *Morgan v. Commissioner of Social Security*, 169 F.3d 595, 598 n.1 (9th Cir. 1999). He concluded as follows regarding DeMaris's ability to work:

> [DeMaris] is able to understand and remember simple instructions. She might have difficulty performing activities within a schedule given the variability in her functional capacity from one day to the next. She appears capable and willing to accept instruction. She is expected to relate interpersonally in a pleasant and cooperative manner with most individuals. Her ability to sustain attention and concentration over time is considered fair. She would probably work in proximity to others without being unnecessarily distracted though her greater distraction would appear to be her physical limitations and pain. She might likely have difficulty setting realistic goals for herself. Her capacity at this time to complete a normal workday is considered markedly limited. She would not appear capable of returning back to the work in which she was trained. Her current psychiatric symptoms of depression and anxiety in combination with her physical conditions would appear to not only support impairment but impairment which would interfere with sustained gainful activity. If determined eligible for benefits it is believed that she is capable of managing these on her own behalf.

(R. 157)

John C. Garfield, Ph.D. performed a Psychiatric Review Technique on June 4, 2001 (R. 168-81), and found DeMaris to have (1) an affective disorder consisting of a depressive disorder, nor otherwise specified (R. 168, 171), and (2) an anxiety-related disorder, not otherwise specified (R. 168, 73). He found neither of these conditions constituted a severe impairment. (R. 168) He found DeMaris to have mild functional limitations in the activities of daily living, ability to maintain social functioning, and ability to maintain concentration, persistence, and pace, and noted she had never had repeated

episodes of decompensation. (R. 178) He concluded DeMaris's impairments did not meet or equal the Listings. (R. 179)

In his review summary, Dr. Garfield noted DeMaris's depression had been stabilized in 1996, when Dr. Brinkman put her on Paxil. Dr. Garfield found no evidence in the file between May 1996 and May 2001, to indicate DeMaris had been treated for any mental disorder. (R. 158) He could not justify Dr. Mayhew's diagnosis of major depression recurrent, noting Dr. Mayhew "gives us no symptoms to justify that diagnosis." (*Id.*) Although Dr. Mayhew gave DeMaris a GAF rating of 48, Dr. Garfield found Dr. Mayhew's "narrative assessment of functional restrictions" indicated DeMaris's restrictions were due to both physical and psychological factors. (*Id.*) Philip R. Laughlin, Ph.D. reviewed the file on September 5, 2001, and concurred with Dr. Garfield's findings. (R. 182)

Dennis A. Weis, M.D. performed a Physical Residual Functional Capacity Assessment of DeMaris on June 9, 2001. (R. 159-66) He found DeMaris could occasionally lift/carry up to 50 pounds occasionally and 25 pounds frequently, and she could stand, walk, and/or sit, with normal breaks, for about six hours in an eight-hour workday, but she had no other exertional limitations. She could climb ramps, stairs, etc. occasionally, and could crawl occasionally, but otherwise she had no postural limitations. He also found she had no manipulative, visual, communicative, or environmental limitations. (*Id.*)

Dr. Weis found that although DeMaris had "severe medically determinable impairments," the impairments did not meet or equal the Listings. He found her "allegations of orthopedic impairments *i.e.* fibromyalgia and spurs on her feet are not supported by evidence contained in the record, eroding her credibility to a degree." (R. 167) Dr. Weis noted that DeMaris's morbid obesity and a small hiatal hernia would

not prevent her from being capable of "a wide spectrum" of the activities of daily living, and he further noted none of DeMaris's treating physicians had provided any estimate of her residual functional capacity. (*Id.*)

DeMaris saw Dr. Brinkman for a follow-up exam on June 25, 2001. (R. 188) She was complaining of dizziness or light-headedness for the prior two months, with no headache, visual change, or unilateral numbness or weakness. She stated she had been checking her blood sugars and they had been within normal limits. She also complained of a sore throat for several days accompanied by chills, and a recurrence of folliculitis at the base of her neck. Dr. Brinkman noted DeMaris's "fibromyalgia symptoms seem to be under improved control with Vioxx and Amitriptyline. She has been a little more active and has been trying to lose weight although [she] is actually increased in weight today [at 258] and is a little depressed and tearful about that." (*Id.*)

Dr. Brinkman ordered lab tests, and directed DeMaris to stop taking Amitriptyline, but continue her other current medications. He prescribed Cephalexin for the folliculitis and for pharyngitis. He told DeMaris to return for follow-up in September to recheck her diabetes, and he referred her to a neurologist for evaluation. (*Id.*) When the lab results came back, they indicated DeMaris's glycohemoglobin was high at 10.4, based on a normal of 4.3 to 6.0, and was under "very poor control." (R. 189)

DeMaris's called the doctor's office on July 3, 2001, to report she was "having a lot of pain from her fibromyalgia." (R. 190) Dr. Brinkman told her to resume taking Amitriptyline, and called in a prescription. (*Id.*)

DeMaris returned to see Dr. Brinkman on July 20, 2001, for follow-up of her diabetes. The doctor recommended she begin taking Glucophage, but noted "she does not wish to do so." (R. 186) Instead, he increased her Actos, and noted she also was taking Norvasc, Accupril, Hydrochlorothiazide, and Prozac. DeMaris reported she was "having

trouble with disability at this time and she has filed an appeal. She is bothered with chronic pain from her fibromyalgia." (*Id.*) Dr. Brinkman's impressions from the exam were exogenous obesity; diabetes mellitus, type 2; and hypertension. (*Id.*) A follow-up mammogram the same day was negative. (R. 187)

On July 24, 2001, DeMaris called Dr. Brinkman's office with complaints of back pain and leg cramps. The doctor prescribed Darvocet-N. (R. 184)

On September 19, 2001, Melodee S. Woodard, M.D. performed a Physical Residual Functional Capacity Assessment of DeMaris in connection with her request for reconsideration of the denial of Title II benefits. (R. 212-19) Exertional limitations were identical to the prior RFC of June 9, 2001. (R. 213-15) Postural limitations also were identical, although the doctor noted DeMaris's "level III obesity may preclude the dexterity needed [t]o crawl or climb ladders on more than an occasional basis." (R. 215) Dr. Woodard did not find DeMaris to have any other limitations. In her review comments, the doctor noted DeMaris had been referred to a neurologist on June 25, 2001, for an opinion, but DeMaris apparently never followed up with an appointment. (R. 219)

DeMaris missed a scheduled appointment with Dr. Brinkman on September 21, 2001. (R. 226) She next saw Dr. Brinkman on October 25, 2001, for follow-up of her hypertension. She reported she could not afford her medications and had been unable to get samples of Norvasc. The doctor switched her to Toprol and stopped the Norvasc. She was told to return in two weeks for a blood pressure check, and in four weeks to see the doctor. (R. 225)

DeMaris called the doctor's office on November 14, 2001, complaining of pain from her fibromyalgia. She asked if she could take one Darvocet a day in addition to her Vioxx. A physician's assistant approved the request, and noted DeMaris was scheduled to see Dr. Brinkman "before he retires for a recheck of her blood pressure." (R. 224)

On November 20, 2001, DeMaris saw Dr. Brinkman for reevaluation of her hypertension. He ordered some lab tests, and directed her to return for follow-up in two months. (R. 223) The doctor subsequently adjusted DeMaris's Amaryl dosage. (R. 222)

After Dr. Brinkman retired, DeMaris began seeing Patrick T. Dunlay, D.O., at the clinic. She saw him on January 25, 2002, complaining of generalized pain, which she reported having for five years. Dr. Dunlay noted DeMaris "has the diagnosis of fibromyalgia but she questions whether or not there might be an underlying neurological problem causing this." (R. 220) She reported intermittent numbness and tingling in her feet, and occasional pain in her left shoulder, right shoulder, and low back. She stated the pain was migratory in nature. She stated she was referred to neurology in June 2001, but she did not recall "that a set date was ever given to her for her neurological appointment." (*Id.*)

Dr. Dunlay referred DeMaris to Marianne Jacobs, D.O. for a neurological evaluation. If Dr. Jacobs failed to identify any neurological cause for DeMaris's pain, then Dr. Dunlay planned to refer her to R. Bruce Trimble, M.D. in the rheumatology department. Regarding DeMaris's diabetes, Dr. Dunlay noted she had run out of her medications four weeks earlier. He gave her samples of Amaryl and Actos, and planned to do blood tests in two months. (*Id.*)

DeMaris saw Dr. Jacobs on February 8, 2002. (R. 227-30) The doctor's findings were as follows:

1. Generalized pain disorder, most likely fibromyalgia. However, neuropathic pain secondary to her diabetes cannot be entirely ruled out.
2. Difficulty with hand grips and dropping things easily, may be related to #1 or separate carpal tunnel syndrome.
3. Paresthesias, numbness, tingling, and visual complaints, again may be related to #1, however, may be diabetic associated

> complaints and/or other neurological illness should probably be ruled out.

(R. 227) Dr. Jacobs recommended testing "to rule out multiple sclerosis, carpal tunnel syndrome, and peripheral neuropathy," but DeMaris declined, stating she did not have insurance to cover the tests. (*Id.*) The doctor counseled her regarding fibromyalgia and pain management, and noted she might need "a stronger narcotic for times when she has more severe pain," but otherwise she did not recommend any change in medications. (*Id.*)

Dr. Dunlay saw DeMaris for a follow-up on March 26, 2002. He continued her current medications, and told her to return in three months for follow-up. (R. 256) On March 28, 2002, Dr. Dunlay noted an endocrinologist had recommended adding Glucophage to DeMaris's diabetic medications, but DeMaris was unable to afford the medication. The doctor stated he would "talk to the pharmaceutical company and see what can be worked out." (R. 255) DeMaris obtained a refill of her Amitriptyline prescription on April 16, 2002. (R. 254)

DeMaris was seen on April 18, 2002, for complaints of menstrual bleeding. A gynecologic examination yielded a diagnosis of "dysfunctional uterine bleeding." (R. 252) She was placed on Prometrium. It was noted that if the bleeding continued, a hysterectomy or possible endometrial ablation would be in order. (R. 251-52)

On May 2, 2002, DeMaris talked with Dr. Dunlay, stating she could not afford to refill her Prozac prescription. The doctor switched her to Paxil. (R. 250)

On May 21, 2002, DeMaris filled a prescription for 60 Darvocet N–100 tablets. (R. 249) She refilled the prescription on June 17, 2002. (R. 248) On July 17, 2002, DeMaris saw M.C. Johnson, M.D. for a recheck of her medications and follow-up on her chronic pain complaints. (R. 246) The doctor noted DeMaris was tearful at the examination. Dr. Johnson's impression was depression, fibromyalgia, and chronic pain

syndrome, and the doctor noted, "I am sure these are all interrelated." (R. 246) The doctor referred DeMaris to the pain clinic, and refilled her Darvocet, noting DeMaris understood the drug was "not for long term use and it is really not the optimal[] management. However, it does make her functional." (*Id.*) An increase in Amitriptyline was recommended, with the possibility of trying Trileptal or Neurontin. (*Id.*)

DeMaris reported she was not checking her blood sugar at home because her machine was broken. The doctor gave her a machine, "and enforced the importance of tight diabetic control." (*Id.*) She was given samples of Glucophage. (*Id.*; R. 243) On July 29, 2002, DeMaris was given samples of Amaryl. (R. 244)

On July 30, 2002, DeMaris was seen for a gynecological and breast examination. She had a small lump in her breast, which the doctor opined was possibly a cyst. DeMaris was scheduled for a mammogram the same day, but the results do not appear in the Record. (R. 245)

On August 26, 2002, a prescription for Hydrochlorothiazide was called into the pharmacy for DeMaris. (R. 242) On September 3, 2002, she was given samples of Vioxx and Amaryl. (R. 241) On September 17, 2002, she was given samples of 30 Norvasc pills, and she received two bottles of 90 tablets from the patient assistance program on September 19, 2002. (R. 23-40) She received more samples of Amaryl on October 4, 2002. (R. 238)

DeMaris was seen at the clinic on October 11, 2002, complaining of back pain. The doctor noted the pain was "[p]robably degenerative in nature," and could be due, at least in part, to DeMaris's "overweight status and her very large pendulous breasts." (R. 237) An X-ray of her lumbosacral spine performed the same day revealed "[p]artial lumbarization of S1"; "slight anterior subluxation of L5 on S1"; "a mild to moderate

degree of degenerative spondylosis through the lumbar and lower thoracic spine"; and "osteoarthritis of the facet joints in the lower lumbar region." (R. 234)

DeMaris called the doctor's office on October 14, 2002, complaining of "pain all over." (R. 236) A prescription for Darvocet was called into the pharmacy. (*Id.*) The next day, DeMaris's Prozac prescription was refilled through the clinic's patient assistance program. (R. 235)

An X-ray of DeMaris's thoracic spine on October 30, 2002, revealed "some degenerative disc disease in the [thoracic] spine, especially lower portion, a little more advanced than what is usually seen at this age, without sign of tumor or infection." (R. 234A)

3. Vocational expert's testimony

The ALJ asked VE Roger Marquardt the following question:

> I'd like [you] to initially consider what effect it would have on [DeMaris's] ability to perform work activity if occasional lifting was limited to 20 pounds, frequent lifting was limited to 10 pounds. She can sit and stand with a change of position every hour or so. She could walk up to one block at a time. Could occasionally bend, stoop, squat, crawl, push or pull, [and] was limited as to climbing. She should engage in simple routine work with no need to do more than basic math or recall numbers or information, so as to be able to relate it to others [sic] as part of the job. With those limitations and abilities, could she return to her past relevant work?

(R. 60) The VE replied that with those limitations, DeMaris could not return to her past relevant work, and she would have no transferable skills to other semi-skilled work. (*Id.*) However, considering DeMaris's younger age, high school education, and "some additional nurse's training," the VE stated there was unskilled work she could do, citing

examples of cashier II, mail clerk, and survey worker. (R. 60-61) He noted that "a portion of those positions also would be sedentary, . . . probably conservatively 20%." (R. 61)

The ALJ then asked the VE to consider the effect it would have on DeMaris's ability to work "if she was only able to maintain activity for 10 to 15 minutes before needing a rest period during which she possibly might need to lie down because of pain and would have to change from a standing to a sitting position every 1/2 hour and then a sitting position for a 1/2 hour." (*Id.*) The VE stated that under those limitations, DeMaris could not perform her past work, there would be no other work in which she could use her transferable skills, "[a]nd in fact any type of competitive employment could not be performed or sustained on a regular and routine basis." (*Id.*)

The VE noted that a marked limitation in the ability to complete a normal workday "would be a barrier to any type of competitive employment." (R. 62) He stated moderate difficulty performing activities within a schedule would not, by itself, change his opinions, but could be a factor when combined with other limitations. (*Id.*)

4. The ALJ's conclusion

The ALJ initially addressed DeMaris's insured status, finding she had "acquired sufficient quarters of coverage to remain insured through June 30, 2001, but not thereafter," and therefore, she had to "demonstrate that she was under a disability on and before that date." (R. 13; R. 20, ¶ 1)

The ALJ found DeMaris had not engaged in substantial gainful activity since her alleged disability onset date of May 31, 1996. (R. 14; R. 20, ¶ 2) He found that although DeMaris had severe impairments consisting of "fibrocystic disease of both breasts; generalized pain disorder, possibly fibromyalgia; diabetes mellitus; high blood pressure;

and abnormal esophageal size," and those impairments "significantly limited her ability to perform basic work activities," they nevertheless did not meet or equal "the level of severity of any impairment described in [the Listings.]" (R. 14; R. 20, ¶ 3)

The ALJ reviewed the medical evidence and DeMaris's testimony, and concluded that in her subjective complaints of limitation, she "paint[ed] a picture far more severe than that documented by the medical record." (R. 17) He noted DeMaris took few medications from 1995 through 1998, and although doctors suspected her pain might be due to fibromyalgia, she had never evidenced sufficient trigger points or symptoms to meet the definition of the disease established by the American College of Rheumatology. DeMaris eventually reported additional symptoms and began receiving regular prescriptions for pain medications, but this occurred after the date she last was insured for purposes of her application for benefits. (R. 16-17) The ALJ further noted that none of DeMaris's treating physicians ever opined she was disabled, and he stated, "The medical evidence showed [DeMaris's] depression as well as her hypertension to be controlled by medication. [She] did not seek counseling or professional mental health treatment, but took medicatio[n]s for anxiety as prescribed by her family physician. Thus, such impairment was not disabling. Likewise, her hypertension was not disabling." (R. 17) He also observed DeMaris had failed to lose weight and exercise as her doctors advised her to do. (*Id.*)

On the issue of DeMaris's credibility, the ALJ noted the issue "cannot be discussed analytically in absolute terms, but must be measured by degree." (*Id.*) He found DeMaris's complaints to be credible, to the extent that he recognized she "may honestly believe that her limitations preclude her from performing work." (*Id.*) However, the ALJ noted his duty was to accurately determine the degree of DeMaris's limitations and her

residual functional capacity based on the evidence as a whole, not just from DeMaris's subjective complaints. He concluded, for the period through June 30, 2001, as follows:

> After careful consideration of the entire record, the undersigned finds that [DeMaris] retained the residual functional capacity to have perform[ed] simple, routine work and that she was able to lift and or carry 10 pounds frequently, 20 pounds occasionally, stand/walk/sit, as long as she could alternate sitting and standing every hour. Additionally, [she] was able to occasionally bend, stoop, squat, crawl, push and/or pull, but she was limited in her ability to climb. Furthermore, she should not have performed work involving more than basic math or the need to recall numbers or information to be related to others as part of the job functions.
>
> . . .
>
> [T]he undersigned finds [DeMaris's] mental impairment had resulted in "mild" restriction of activities of daily living, maintaining social functioning, and "moderate" limitations in her ability to maintain concentration, persistence and pace. The undersigned further concludes that [DeMaris's] mental impairment had resulted in no episodes of deterioration or decompensation.

(R. 18; *see* R. 20, ¶ 4)

The ALJ found DeMaris could not return to her past relevant work, but she retained the residual functional capacity to perform light duty jobs that exist in significant numbers in the local and national economies, citing examples of cashier II, mail clerk, and survey worker. (R. 19, 20-21) He therefore concluded DeMaris "was not under a disability on and before the date her insured status expired" (R. 19), and she therefore was not entitled to DI benefits. (R. 20, 21)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the

Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id.*; *accord Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)).

Step five requires that the Commissioner bear the burden on two particular matters:

> In our circuit it is well settled law that once a claimant demonstrates that he or she is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

Nevland v. Apfel, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added); *accord Weiler v. Apfel*, 179 F.3d 1107, 1110 (8th Cir. 1999) (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work,

and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

B. The Substantial Evidence Standard

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Weiler, supra,* 179 F.3d at 1109 (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley, supra,* 133 F.3d at 587 (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler, id.*; *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier,* 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell, id.; Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier,* 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997); *accord Pearsall,* 274 F.3d at 1217; *Gowell, supra*.

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.,* 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not

discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala,* 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;
> 5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

IV. ANALYSIS

In her brief, DeMaris argues the ALJ, in his analysis, repeatedly focused on isolated evidence in the Record that supported his conclusions, rather than considering the evidence as a whole. Chief among her assertions of error is DeMaris's argument that the ALJ improperly discounted her subjective pain complaints, and focused instead on the doctors' failure to reach a definitive diagnosis to account for her pain. She asserts the ALJ improperly rejected Dr. Mayhew's opinion and improperly concluded that she retained the residual functional capacity to perform substantial gainful activity. (Doc. No. 7)

DeMaris, in her brief and her reply brief (Doc. Nos. 7 & 11), and the Commissioner, in her brief (Doc. No. 10), express conflicting views of the impact of the totality of the evidence regarding DeMaris's subjective pain complaints. DeMaris points out that her treating doctors never discounted her pain complaints, and prescribed pain medications when she requested them. She notes courts have recognized the inherent difficulty in diagnosing many medical conditions, and the Eighth Circuit has instructed that doctors' failure to diagnose the cause of a condition "does not make that condition any less disabling" when objective medical evidence exists to support a claim of disability. (Doc. No. 7, p. 8, citing *Jackson v. Bowen*, 873 F.2d 1111, 1114-15 (8th Cir. 1989)). DeMaris further argues the ALJ erred in concluding that consulting psychologist Dr. Mayhew improperly considered DeMaris's *physical* limitations in opining she has a markedly limited capacity to complete a normal workday, asserting instead that Dr. Mayhew only mentioned DeMaris's physical complaints "in connection with her susceptibility to distraction, a mental characteristic that he was qualified to assess as a licensed psychologist[.]" (Doc. No. 7, p. 12) DeMaris also argues the ALJ's RFC determination was "unrealistic and unsupported by the evidence," relying on her subjective pain complaints and Dr. Mayhew's opinion. (*Id.*, p. 10)

The Commissioner argues DeMaris failed to comply with treatment recommendations on a frequent basis; her symptoms often were controllable when she took her prescribed medications; and she continued to engage in a full range of daily activities throughout the relevant period. (Doc. No. 10) The Commissioner asserts the ALJ properly discounted Dr. Mayhew's opinion because Dr. Mayhew only performed a one-time evaluation, he was not DeMaris's treating psychologist, and his opinion was not supported by the evidence. (Doc. No. 10)

The parties both argue their cases persuasively, with appropriate citations to relevant authorities and the Record to support their arguments. The very fact that evidence exists in the Record to support *both* parties' arguments makes this case the type the Eighth Circuit discussed in *Roe, supra*. Here, as in *Roe*, the court finds it "possible to draw two inconsistent positions from the evidence." *Id.*, 92 F.3d at 675. In such a case, the court is not permitted to "reweigh the evidence or review the factual record *de novo*." *Id.* Rather, when one of the inconsistent positions represents the Commissioner's decision, the court "must affirm" that decision, *id.*, even if the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citations omitted).

The court does not doubt DeMaris experiences chronic pain that could make work uncomfortable for her. However, as the Eighth Circuit held in *Johnson v. Chater*, 108 F.3d 942, 947 (8th Cir. 1979), the mere fact that working may cause pain or discomfort does not mandate a finding of disability." (Internal quotation marks, citation omitted.) Indeed, as workers age, it is likely the majority experience some degree of daily discomfort, whether physical or mental or both, related to the demands of their jobs. This does not render them disabled, as defined by the Social Security Act and its implementing regulations.

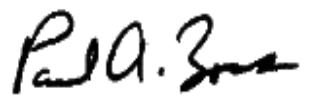
The court finds the ALJ's determination of DeMaris's RFC and ability to perform light work is supported by substantial evidence in the Record as a whole. The court further finds that although the Record contains evidence to support the contrary position, the Record contains substantial evidence to support the Commissioner's determination that DeMaris was not disabled at any time through June 30, 2001, and she therefore is not entitled to DI benefits.

V. CONCLUSION

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[1] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that the Commissioner's decision be affirmed, and judgment be entered for the Commissioner and against DeMaris.[2]

IT IS SO ORDERED.

DATED this 13th day of November, 2003.



PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

[1]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

[2]NOTE: If the district court overrules this recommendation and final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.